Connecticut Vaccine Program

2014 Provider Profile

Completed forms can be FAX to: 860-509-8371 or email: DPH.IMMUNIZATIONS@ct.gov

All public and private health care providers who receive vaccine from the Connecticut Vaccine Program **(CVP)** must complete this form. This document provides shipping information and helps to determine the amount of vaccine to be supplied. The form is also used to compare estimated vaccine needs with actual vaccine supply. The Connecticut Vaccine Program will keep this record on file with the SIGNED **"Provider Agreement"**. The Provider Profile form must be updated annually or if: (1) the number of children change, or (2) the address of the facility changes. **Complete one Provider Profile for each office/site/satellite.**

PIN Number
____ ____ ____ ____

Federal Employer Tax ID	Please Check One
____ ____ ------ ____ ____ ____ ____ ____ ____ ____	☐ Re-Enrolling in CVP ☐ New Provider

Facility Shipping Address (Vaccine Delivery Location)

Facility Name		Primary Vaccine Coordinator Contact Name and Title	
		Back Up Vaccine Coordinator Name and Title	
Vaccine Shipping Address (No P.O. Boxes)		Floor or Suite #	Email Address
City	Zip Code	Direct Phone Number to Contact Person	Fax Number

Facility Mailing Address (If Different From Delivery Location)

Mailing Address	
City	Zip Code

Office Days and Hours Staff Available to Receive Vaccine Shipments

Monday	Tuesday	Wednesday	Thursday	Friday

Include any time during normal business hours when the office is closed and will not accept vaccine deliveries.

List of All Providers Who Administer Vaccines

First & Last Name	Title	CT License #	Medicaid Billing #	Group Billing #

Type of Facility (check one)

- ☐ Local Health Department
- ☐ Federally Qualified Health Center (FQHC) or Federally Funded Rural Health Clinic (RHC)
- ☐ School Based Health Center Clinic
- ☐ STD/HIV Clinic
- ☐ Drug Treatment Facility
- ☐ Family Planning Clinic
- ☐ Birthing Hospital
- ☐ Private Practice (Individual or Group)
- ☐ Hospital Clinic
- ☐ Other (please specify)

Specialty (check one)

- ☐ Pediatrics
- ☐ Family Medicine
- ☐ Primary Care
- ☐ OB/GYN
- ☐ Internal Medicine
- ☐ Allergy
- ☐ Urgent Care Center
- ☐ Other (please specify)

Patient Enrollment

All practices must provide total patient enrollment numbers by age group and insurance status in order to receive vaccine from the CVP. New providers can give an estimate.

Total Patient Enrollment

	Birth to 1 yr.	1 - 6 yrs.	7 -18 yrs.	Total
Total Number of **All** Patients in your practice who will be administered state supplied vaccine:				

Patient Insurance Status Do not count a patient in more than one category or use percentages.

The total of 1-6 below must equal the total patient enrollment listed above

	Birth to 1 yr.	1 - 6 yrs.	7 - 18 yrs.	Total
1 Number of Privately Insured Patients				
2 Number of Medicaid Enrolled Patients (HUSKY A)				
3 Number of Patients Without Insurance				
4 Number of Patients who are American Indian or Alaskan Native				
5 Number of S-CHIP Enrolled Patients (HUSKY B)				
6 Number of Underinsured Patients				

Data Source

What data source was used to determine the total number of patients and insurance status provided above:

☐ Immunization Information System ☐ Billing System ☐ Electronic Health/Medical Records ☐ Other, specify _____

Storage Units

Please indicate the type of storage unit(s) used to store state supplied vaccine (check all that apply)

☐ Stand Alone Refrigerator Unit ☐ Stand Alone Freezer Unit ☐ Single Door Refrigerator & Freezer Unit (Dormitory Style)

☐ Double Door Refrigerator and Freezer Unit (top/bottom or side by side)

Temperature Monitors

Indicate type of temperature monitors used in storage

☐ CVP Supplied Continuous Read Dickson Thermometer

☐ Dial Thermometer

☐ Liquid Temperature Probe

☐ Data Logger

☐ Specify:

PLEASE remember to sign the *accompanying "Provider Agreement"* .

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